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ABSTRACT

The category of attention deficit disorder is defined in terms of diagnostic symptoms (inattention, impulsivity, and hyperactivity) and definitions. Aspects which need to be covered in the classroom evaluation of a child with suspected attention deficit disorder are reviewed, including examination of the task for its appropriateness; determination of a specific learning disability in the child; observation of the setting (including the classroom order, acceptance, and the teaching style); and finally, consideration of the child (existence of emotional stress, neurological problems, and mild hearing loss). (Case histories are presented to illustrate assessment considerations.) (CL)

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ASSESSMENT OF CHILDREN WITH ATTENTION PROBLEMS

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Paper to be presented at the Council for Exceptional Children's Convention in Houston, Texas on April 16, 1982 as part of a symposium with Dr. Paméla George on "Promoting Attention-to--Task in Children with Learning Problems: Techniques from a Research, Clinical, and Classroom Perspective."

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The purposes of this section are first, to review current definitions and diagnostic criteria for children with attention problems, especially Attention Deficit Disorders and second to discuss evaluation of attention difficulties as an educational problem and also as an indication of other disorders.

An Attention Deficit Disorder, as defined by the Diagnostic and Statistical Manual (DSM III) of the American Psychiatric Association in 1980 has the essential features of developmentally inappropriate attention and impulsivity. In the past, children with these characteristics have been labelled as having Hyperkinetic Syndrome, Hyperactive Child Syndrome and Minimal Brain Dysfunction. In the new diagnostic category, two subtypes of this disorder are defined: Attention Deficit Disorder with hyperactivity and Attention Deficit Disorder without hyperactivity. Also, a residual subtype is defined for individuals who have been diagnosed as having an Attention Deficit Disorder with hyperactivity in which hyperactivity is no longer present but other signs persist.

The pattern of behavior is typically apparent by age 3 and before age 7, but is frequently not a major concern until the child enters school. The peak age for referral is between the ages of 8-10 when environmental expectations require more sustained attention and self direction. Diagnostic symptoms are listed in three categories:

Diagnostic Criteria for Attention Deficit Disorder with Hyperactivity

A. Inattention. At least three of the following:
   (1) often fails to finish things he or she starts
   (2) often doesn't seem to listen
   (3) easily distracted
   (4) has difficulty concentrating on schoolwork or other tasks requiring sustained attention
   (5) has difficulty sticking to a play activity

B. Impulsivity. At least three of the following:
   (1) often acts before thinking
   (2) shifts excessively from one activity to another
   (3) has difficulty organizing work (this not being due to cognitive impairment)
   (4) needs a lot of supervision

(5) frequently calls out in class
(6) has difficulty awaiting turn in games or group situations

C. Hyperactivity. At least two of the following:
(1) runs about or climbs on things excessively
(2) has difficulty sitting still or fidgets excessively
(3) has difficulty staying seated
(4) moves about excessively during sleep
(5) is always "on the go" or acts as if "driven by a motor"

Diagnostic and Statistical Manual of Mental Disorders (Third Edition) American Psychiatric Association. Washington, D.C. APA, 1980.

The other type of an Attention Deficit Disorder is without hyperactivity and is described by the same features of inattention and impulsivity, but without hyperactivity. These are the children in the classroom who have difficulty staying on task and completing any work on an independent basis. They may give the impression that they are not listening, their work is sloppy and usually performed in an impulsive fashion. In making this diagnosis, teachers and parent observations are of primary importance as the child may exhibit none of these symptoms in a clinic or one to one situation. What may be observed in a clinic or on individually administered tests are careless and impulsive errors. The child's performance is often erratic with the child missing easy items and passing much more difficult ones. Oversights and omissions are common even when the child is well motivated. At home, attentional problems are shown by a failure to follow through on parental requests and inability to stick to activities including play for periods developmentally appropriate.

Also the Manual describes an Attention Deficit Disorder of a residual type in which signs of hyperactivity were once present at a younger age and no longer exist, but other symptoms remain as diffculty concentrating, being easily distracted and making sudden decisions without thought of the consequences.

This diagnostic category of an Attention Deficit Disorder appears to have the usual advantages and disadvantages of labels used with exceptional children. The advantage being that many children may receive more professional attention and have their behavior patterns understood better by school personnel. The

disadvantage being that there are no clearcut diagnostic criteria or consistent patterns so a wide variety of children with very different styles and problems will be labelled and parents will be bewildered when presented with this diagnosis, and will undoubtedly receive lots of mixed information from professionals with different experiences. Clinicians and professionals will continue to be frustrated with trying to decide who is and who isn't or who does and who doesn't but the general net result to the classroom teacher will change very little. Classroom teachers will be faced with the same problem of managing and teaching the child whether he/she is called ADD, hyperactive, hyperkinetic or hydrachloric.

In the second part of this paper, I would like to address the issues of evaluating a child in a classroom and to cover some of the factors and questions teachers and professionals should be aware of in evaluating children with attention difficulties. There must be awareness of all three of the factors in the interactionist model as described above, the task, the setting and the child. At this point, the focus will be on observing and collecting information in order to plan a program. While this is important for all children it is especially critical in the case of hyperactive children with attention disorders. Frequently, the teacher and parent reports are the primary basis for making a decision about medication, and in making an accurate diagnosis. Careful and accurate observations of the child with attention disorders are a necessary first step in planning educational, medical and/or psychological programs.

The Task

When concerns are raised about poor attention, a logical first step is to look at the task being required.

1. Are the tasks educationally and developmentally appropriate?

To answer this, one needs to know the child's skill levels and academic achievement. The curriculum may be too difficult or too easy. Criterion

reference testing, IQ or achievement tests may be helpful in determining if a child's educational program is appropriate. An understanding of the child's specific strengths and weaknesses is helpful in understanding on which tasks a child is likely to be inattentive.

It is not uncommon to find children whose achievement scores are average on individually administered or short achievement tests, but who are not performing at all in the classroom, i.e., no homework or class assignments are completed. However, the child appears to be learning in spite of his behavior.

2. Does the child have a specific learning disability?

While most teachers are alert to children with specific reading or math disabilities, they may overlook the child with language processing problems. The primary concerns or description of behavior by a teacher may sound like an attention problem. The child doesn't follow directions, doesn't complete assignments, i.e., does one thing and quits, is in his own world. He or she doesn't seem to know what's going on in class or with peers, but is very creative and productive when working on their own project.

In this case, a teacher or professional, needs to be aware of the possibility of language processing problems. Assessment techniques are still developing but there are several types of information which may be helpful.

1. Standardized test scores on language tests.

2. Discrepancies on language vs non language based learning and cognitive tasks, i.e., high calculation vs low on word problems - or good spelling and phonics and low reading comprehension, higher WISC scores on non-veral subtests.

3. Observation of the child to note when the child is off task. For a child with a language processing problem, it will be most noticeable when directions are given orally, when more than one is given at one time and when there are different directions for different groups. These children will sometimes learn to be very good observers and imitators of others and become particularly difficult when there is a break in routines. Some children will do much better with written instructions and some will do much better with individual or small group instructions.

These children have attention problems that are secondary to language problems. If you describe and observe their behavior carefully, you can see a pattern and refer them for language help or further evaluation.

The following information from a school on a first grade child would be an alert sign for looking for a language problem.

"His responses, both verbal and physical are often inappropriate. His attention span is very short, except when he is doing what he wants to do. He is a loner but he has improved in this area during the school year. His spelling and word recognition are average to good with undetermined comprehension."

Also there are children with visual-motor weaknesses who manage to cope with the first two or three grades fairly well because (1) a limited amount of writing is expected and (2) there is a higher tolerance for immature writing styles. When these children reach third or fourth grade and they are faced with long writing assignments, they will frequently be described as unmotivated, lazy, inattentive, distractible and avoidant. They can and will manage many creative diversions including getting into trouble to avoid writing tasks. If you say this behavior may describe easily half of any fourth grade class, and is certainly not a diagnotic category, I will agree with you. However, one does need to be aware of the children who have a consistent pattern and developmental history of visual-motor difficulties and who have slow and/or careless handwriting. These children often develop an avoidance of all written tasks and may look like a child with an ADD. Evaluating the child for a visual motor problem may involve (1) finding out about his history of VMI problems, (2) comparing his handwriting on a variety of tasks and (3) comparing his handwrdting speed and style to his peers.

It is frequently only the teacher who works with a child over a long period of time who can discriminate a child with inattention due to visual

motor problems and a child who cannot sustain attention to any task for very long.

Case Study

Dale is a 12 year old seventh grader whose developmental history was reported as being normal by his mother. He was active, but well behaved and somewhat advanced in that he could read signs at 3-4 years of age. For the first through third grades, he got strong to average grades. In the fourth and fifth grades, he started going down and in the sixth grade he "did horrible" and got almost all failing grades. Dale and his parents considered this sixth grade teacher to be unfair, in that she did not even attempt to read his writing but would grade him down if he didn't finish his work, didn't turn it in or the writing was too messy. According to his mother, achievement scores have been good, indicating that he was learning, but because of his refusal to do his work, he has been getting low grades. As a result, one parent will sit with him for 2-3 hours per night and "prod him along." In addition, he doesn't admit to having homework so that now the school is sending home notes.

An interdisciplinary evaluation showed he had average intelligence, Full Scale 104, with delays on visual motor tasks, and above average in math, general information skills and reading comprehension. Delays were noted in the written language skills of spelling, writing mechanics, and handwriting. A medical evaluation revealed good gross motor skills with some clumsiness in fine motor abilities noted in rapid alternating movements of his fingers and hands.

Dale's style was impulsive but his problem solving style was logical and organized. He had a low perception of himself on writing and drawing tasks but felt confident in other areas. He had positive perceptions of his parents but felt expectations were too high and punishment too severe for poor performance.

Factors felt to contribute to school failure are (1) difficulty with visual-motor tasks and delays in all written language tasks, (2) pressure of failing to meet parental expectations and (3) reaction to history of poor parent-school interactions.

Setting

1. Is the classroom organized and orderly?

Some children will look hyperactive, distractible and impulsive in one setting and not look at all inappropriate in others. Children in inadequate, disorganized or chaotic environments may appear to have an attention disorder when their response is environmentally determined. The unorganized enviornment may be at home or at school. In the case of the school, often one can easily observe that the classroom lacks structure or direction from the teacher or children. In such a situation, getting the educational history

of the child from the parent or counselor may be helpful. A child referred for attention problems in the fourth grade with no history of problems before, needs to have his educational setting evaluated.

2. Is the atmosphere accepting or rejecting?

Other factors besides classroom organization and structure are the acceptance or rejection of the child by the teacher. Also the amount of tension or anxiety in the class may be a key factor. A child's behavior, like yours and mine, reacts markedly to an accepting, relaxed atmosphere as opposed to a rejecting anxious environment.

3. Is the class teacher-directed or child-directed?

Another factor is the amount of teacher-directed vs self-directed work, and the child's response to that style. Whereas an hyperactive impulsive child responds well to a teacher directed and controlled lesson, some gifted and/or self motivated children become quite inattentive and non-productive in highly controlled situations. The interaction of the child's needs and the setting has to be observed and evaluated.

Observational systems of all types have been developed and you can develop one to suit your needs. The essential criteria need to be

1) specification of meaningful, well described target behavior
2) a place to record the time, setting and task
3) a place to note the consequences of the behavior

Observations can be for a set amount of time every day, but this is usually difficult for a classroom or resource teacher to handle. An alternative is a sheet for notes about a child's behavior to force yourself to observe systematically but not totally occupy your time.

Child

Attention problems are also a common indication of emotional problems or family stress in a child's life. They may be a result of a child who is anxious, and under pressure to meet parental or personal high expectations. An impulsive distractible style may be due to a fear of failing and resistance to trying.

Case Study

Larry was referred by the school system with concerns about his lack of attention, absent mindedness and appearance of being sleepy or tired. A school visit revealed a well organized, caring teacher who had tried a number of different approaches to improving his attention. It also showed that Larry could concentrate and stay on task at times when someone was sitting in the back of the class observing him. Educational history, as presented by the mother, indicated Larry had always had some difficulty with activity level in the early grades and attention to task problems in the fourth and fifth grades. Second grade was a good year with an exceptional teacher.

The interesting aspect of this case is that Larry went through the entire evaluation process and the only factor contributing to his poor school performance was his somewhat impulsive style. Larry was brought back for a second psychological interview and the father was invited to come in for an interview. This second look uncovered a family falling apart with Larry's mother moving out. Larry's father was extremely sad, and guilty about this, but anxious to do what he could to work things out. Larry admitted to being concerned about losing one of his parents and to thinking a lot about family problems in class.

Larry's family problems did not account for all his attentional problems but they certainly exacerbated his inattentive, impulsive style by preoccupying his thoughts. Larry's teacher knew something was keeping her from controlling Larry's attention even with effective behavior management techniques. By referring Larry for more help, the whole family has ended up in therapy and is back together.

Another area that may be cause for inattention in a child is an underlying neurological or physical disorder. Although these are rare and found in only a very small percentage of the number of children with attention problems, it is frequently the observant teacher who recognizes an undetected child. One of these disorders which may look like inattention is epilepsy. A child having petit mal seizures will have staring spells usually associated with rapid eye blinks. This child may appear to have missed information and to be somewhat disoriented in time and space.

Case Study

Rick was a 7 year old boy who had spent two years in a language classroom. He was on a low dose of Phenobarbital due to seizures experienced as an infant. He was referred for an interdisciplinary evaluation by his teacher in the language classroom because of minimal school progress, attentional problems, following directions, tuning out, and possible seizures. They observe "Rick often seems to be in a daze that he doesn't seem to be able to control. Activity level and attention span vary daily."

Rick had already had a complete interdisciplinary evaluation soon after being placed in the language class, and no neurological or seizure disorder was found. He was seen regularly by his pediatrician who also had no concerns about Rick but felt he had some "autistic behavior." An EEG was normal and Rick's mother reported no concerns regarding seizures but felt that his periodic head nodding behaviors related to a voluntary means of "avoiding going to the bathroom."

Rick's teacher persisted in the face of this, requesting another interdisciplinary evaluation and was proved to be absolutely right by a pediatrician who had him hyperventilate and was able to document a series of petit mal seizures.

Currently he is functioning in the borderline range of intelligence and is functioning two years behind his age expecations. Language delays are also noted to be in the moderate range with difficulty in organizing his expressive language, verbal perservation and lapses in attention.

Also, child who have mild hearing loss may appear to have an attention deficit with difficulty in following directions. Of a similar style, is the children who have chronic respiratory problems accompanied by ear infections. These children frequently suffer mild hearing loss for two weeks around an infection which may affect their behavior.

These conditions, whether medical or emotional, are often picked up by teachers who realize the child's behavior is different and describe it carefully so that the child can get appropriate outside help.

In closing, there are a few points to re-emphasize:

1) The category of attention deficit disorder includes a much broader group of children than the old labels of Hyperactive and Hyperkinetic.

2) The new term can be helpful in developing an understanding of attention problems and harmful if it is seen as a total explanation or excuse for inattention in children.

3) Attention problems are often symptoms or indications that a closer look needs to be taken at the child, the setting and the task.